2023375459

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/05/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 ON) PROVIDER/SUPPLIERICLIA 02) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (XI) DATE SURVEY COMPLETED A BUILDING 09G152 05/29/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN'S COMMUNITY SERVICES, INC 5012 MILITARY RD. KW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FIRL REGULATORY OR LISC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE TAG TAG DEFICIENCY W 000 INITIAL COMMENTS W 000 The Governing Body seeks On April 29, 2009, at approximately 1:38 PM, the to ensure that all State Agency (SA) was notified via telephone incidents surrounding message, by the Day Program Case Manager, to report an allegation of abuse that involved Client allegations of abuse and #1 which allegedly occurred in his group home on neglect are reported in April 29, 2009. He reported that a group home staff (no name given) had bent his left arm accordance to the policy towards his back, when told that he needed to go and procedures in place to the bathroom to wash up for the day program. for situations involving Due to the nature of the incident and information individuals being served. obtained from the administrative review on May 4, 2009, an on-site investigation was initiated on May 29, 2009 by the SA, to verify compliance with A) The allegation of abuse federal regulatory requirements. Findings of the was reported in accordance investigation were based on observations at the group home and one day program, interviews to the facilities policy. with Client #1, group home and day program The governing body policy direct care staff, nursing and administrative staff, and review of client and administrative records: indicates that all including incident reports. allegations shall be brought to attention of As a result of the findings, the SA could not substantiate that Client #1 was physically abused and reported to the by one or more staff persons. However a Program Director. In this 4/28/09 determination was made that the facility failed be in compliance with the standard level case this was done by the requirements in Client Protections as evidenced house manager. by: A) The facility failed to report the aforementioned B) The house manager alleged abuse as required by the facility's policy and by federal and local regulations. notified Client #1's grand -mother and was informed B) The facility failed to notify promptly the client's that she was already guardian of an allegation of abuse, aware. C) The facility failed to report the results of all

Any deficiency statement ending with an asterist (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclossible 90 days following the data these documents are made available to the facility. If deficiencies are cited, an approvad plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

TITLE

O(6) DATE

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 06/05/2009
GENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) N A. BU		PLE CONSTRUCTION G	OMB NO. 0988-0: OCS) DATE SURVEY COMPLETED	
		09G16\$	8. Will	NG		1	C
name of	PROVIDER OR SUPPLIER			-		05/2	9/2009
	N'S COMMUNITY SER			30	EET ADDRESS, CITY, STATE, ZIP CODE 012 MILITARY RD, NW (ASHINGTON, DC 20015		:
(X4) ID PREFIX TAG	REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REPERENCED TO THE APPRI DEFICIENCY)	it to their	COMPLETION DATE
W 000	Continued From pag	je 1	We	ma	C) Client #1's day pl	acemen	
	investigations to the representative or to with State law within incident.	administrator or designated other officials in accordance five working days of the			had already reported incident to the prope authorities. The alle	the r	
W 148	483.420(c)(6) COMM CLIENTS, PARENTS The facility must not	S &	W1	48 v	was reported to the agency's Incident Management Coordinato		
	changes in the client limited to, serious ilin or unauthorized abse	•		S	(IMC). IMC reported to the was already in the system. An agency reports was completed and an	ê	4/28/09
	tailed to notify promp member/medical aun	not met as evidenced by: not record review, the facility thy the client's family rogate of an allegation of client in the investigation.	•	i w b	nvestigation was inition the staff in questing placed on administrative leave madiately.		
ļ	The finding includes:			_	unlediately.	ì	
	29, 2009, on May 27, PM submitted by the prevealed Client #1 has (no name given) at his left arm towards his b	l incident report dated April 2009, at approximately 5:00 Day Program Case Manager d alleged that a staff person a group home, had bent his ack, when told that he athroom to wash up for the					
1	May 26, 2009, at appr revealed Client #1 had his legal medical sumo revealed the facility no	idential Team Leader on oximately 10:55 AM a family member who was ogate. Further interview office of the allegation of			•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIENCIA IDENTIFICATION NUMBER:		(XZ) MU A. BUIL	LTIPLE CONSTRUCTION DING	OMB NO, 09384 (X3) DATE SURVEY COMPLETED		
		09G168	B. WING			c
	PROVIDER OR SUPPLIER N'S COMMUNITY SER	VICES, INC		TREET ADDRESS, CITY, STATE, ZIP COD 3012 MELITARY RD, MY WASHINGTON, DC 20015		29/2009
(X4) ID PREFIX TAG	LACK DEFECTION Y	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE	ECTION HOULD BE PROPRIATE	COMPLETION DATE
W 149	dated April 9, 2007, approximately 12:10 have a family membi surrogate.  There was no documotified promptly the client's family membi allegation of abuse.  483,420(d)(1) STAFI CLIENTS  The facility must device policies and procedumistreatment, neglections and procedumistreatment, neglections are interview a failed to implement exporting all unusual clients to the State Accilent in the investigation of an unusual client in the investigation of the finding includes:  Review of an unusual 29, 2009, on May 27, PM submitted by the revealed Client #1 have alled the first management of the first submitted by the revealed Client #1 have alled the first management in the first submitted by the revealed Client #1 have alled	rement of Developmental fical surrogate document on May 28, 2009, at PM revealed Client #1 did er who was his legal medical mented evidence the facility er/medical surrogate of an FTREATMENT OF elop, and implement written res that prohibit it or abuse of the client.  The mot met as evidenced by:  The mot met as evidenced by:	W 14	completed inter-age report that indicate Client #1's family notified of the all The family indicate they were already nof the allegation.  The facility implements policy on unusual incidents regarding neglect or abuse of individual. It was immediately to the Director, Incident Management Coordinate QMRP, and his family staff that was on should the time of the allegation without pending the results investigation.	es that was egation. d that otified ented al abuse, an reported Program for, I Both lift at eged i on bay	

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES			,		<b>.</b>
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	D: 06/05/2009 MAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDENSUPPLIERICLY IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLICE/CT LA	(XZ) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (XS) DATE SURVEY COMPLETED	
		09G168	B. Wil	NG_		Ì	C
NAME OF	PROVIDER OR SUPPLIER					05/	29/2009
HOL TE	N'S COMMUNITY SER	VICES, INC		3	GET ADDRESS, CITY, STATE, 219 CODE 612 MELITARY RD, NW VASHINGTON, DC 20015		
(X4) RD	SUMMARY STA	TEMENT OF DEFICIENCIES	J	_			
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PRET		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOIL CROSS-REFERENCED TO THE APPR DEFICIENCY)	T IS DOC	CDMPLETION DATE
W 149	Continued From page		W 1	40		<del></del>	
	May 28, 2009, at ap	proximately 10:00 AM	, ,,		The allegation		
	; revealed the Day Pr	Octani Casa Manager		i	was reported to the		!
	3:10 PM of Client #1	ril 29, 2009, at approximately I's allegation of abuse, in an			agency's Incident		i
٠ .	MINITED AND THE PORT OF PARTY IN THE PARTY I	BSidential Team I Aerier on		- 1	Management Coordinato		
j	i May 25, 2009, at ab	DCOXIMATely 11:10 AM # was		1	_		
ĺ	the allegation of shirt	he facility did not document ise and failed to notify the			(IMC). IMC reported t		} .
	Department of Healt	h (DOH) of the allegation of			the was already in th		4/28/09
ļ	ANNAR LADOLENG DA (?	DOOC 90   ANAIL 20 2000			system. An agency rep	ort	i : [
į	according to the faci	lity's policy.			was completed and an		
1	Interview with Client	#1 on May 28, 2009, at			investigation was ini		: [
	approximately 11:50	AM revealed alleged that "a		ľ	with the staff in que	stion	
1	man "(no name give	n) at his group home, had ards his back, when told that			peing placed on		
	UB USSOCIO GO TO IT	18 Dathtoom at 6 Noleak			administrative leave	ļ	
ľ	(date nukhowy) to w	36h un for the day program			immediately.		• 1
i	LALIDEL SUBSIVIEW DEV	ealed Client #1 only reported se to the Day Program Case					
1	Manager.	se to use Day Flogram Case					
1	<u></u>					į	
1.	Mile Lic Way 28 2000	ensed Practical Nurse (LPN at approximately 1:10 PM		!			ľ
1 1	HAVE UP JEUT DOUGEVE	29, 2009, at approviment, I		i		}	
,	III.ZV ANI, CHEMEST S	Medel that "a man" in his				i	
11	group nome best his	left street towards him hands				İ	
- 1	for the day program.	to the bathroom to wash up Further interview revealed				1	
	∪nent #1 was observa	ed to have a small scratch		Ì		}	
	on the inner aspect of	f his left arm.				}	<u> </u>
- 1	nterview with the LPA	#2 on May 28, 2009, at		ĺ			
		M revesied that on Anal on		İ		1	` }
· · ·	CUUV, at approximate	V 10:15 AM Chant #4 manual		1		; :	
} <b>u</b>	nat ne nad a scratch ind needed treatment	BITAL TIDAIDO INIA A UNIVAC				j	-
Į (T	evealed on that same	day at annowing tok: 44.00		i			
J.A	M, Client #1 returned	to the nursing station					
104 600 000 0000	***			1		i	: I

2023375459

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/05/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING B, WING 09G168 NAME OF PROVIDER OR SUPPLIER 05/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN'S COMMUNITY SERVICES, INC 2012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION D PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION TAC DEFICIENCY W 149 | Continued From page 4 Client#1 family was W 140 accompanied by his case manager and alleged notified of the allegation 4/28/09 that someone in his group home had bent his and an incident report was ann. completed. Interview with the Day Program Case Manager on May 29, 2009, at approximately 1:44 PM revealed that Client #1 reported that "a man" in the group home bent his left hand behind his back when he refused to go into the bathroom to wash up for the day program on April 29, 2009. A telephone message was left at the group home (time unknown) on April 29, 2009, regarding Client #1's allegation of abuse. Further interview revealed the facility's Residential Team Leader called the Day Program Case Manager on April 29, 2009, at approximately 3:05 PM and was informed of Client #1's allegation of abuse. This is a known behavior for Review of Client #1's Psychological Evaluation Update dated June 2, 2008, on May 28, 2009, at Client #1 and it continues approximately 11:30 AM revealed The frequently to be included in his complains and tells falsehoods about the staff, psychological assessment. and he sometimes threatens he'll get a staff member fired". This behavior was dropped from his behavior data Review of an Incident Reporting policy dated October 2008, on June 1, 2009, at approximately sheets due to no 6/15/09 4:50 PM revealed the facility "shall have written occurrences in some time, documentation of all unusual incidents that impact the person served" (i.e. "instances of This information was shared alleged or suspected abuse") "incident reports" with the psychologist. will serve to notify and inform the administration, applicable state agencies, and provide documentation for subsequent review and investigation of incidents. There was no documented evidence the facility implemented its established procedures of reporting all unusual incidents that impact the

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			DRIME	
CENIE	RS FOR MEDICARE	& MEDICAID SERVICES			FOR	D: 06/05/200 MAPPROVE
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTERCATION NUMBER:		(X2) MUI	LTIPLE CONSTRUCTION	OMB N	Q. 0938-039	
		09G168	& WING			¢ :
NAME OF F	ROVIDER OR SUPPLIER		<del></del>		05	/29/2009
	rs community ser		1	TREET ADDRESS, CITY, STATE, ZIP C 3012 MILITARY RD, NW WASHINGTON, DC 20015	ODE :	<del>.</del> !
(X4) ID PREFIX TAG	REGULATORY OR LE	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (FACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEPICIENCY)	N SHOULD BE APPROPRIATE	COMPLETION DATE
}	Continued From pacification to the SA,		W 149			<del></del>
W 158	483,420(d)(4) STAF CLIENTS	F TREATMENT OF	W 156	3		
į	IN ING SOMMISTISTOR	estigations must be reported or designated representative accordance with State law ays of the incident.				;
	Based on staff interviolating facility failed to ensu incidences of potentials	not met as evidenced by: iew and record review, the re that investigations into all or actual harm were working days for one of one tion. (Client#1)		The allegation was reported to the agency's Incident		:
Ī	The finding includes:			Management Coordin (IMC). IMC reporte	d that	
t f v C ii F 2	Management Coording proximately 11:00 2009, Client #1 had a Case Manager that a given) at his group he owards his back, who the bathroom to wards his back, who the bathroom to wards his pack, who the bathroom to wards immediately plant immediatel	with the facility's Incident nator on May 29, 2009, at AM revealed that on April 29, alleged to the Day Program staff person (no name one, had bent his left arm an told that he needed to go sale up for the day program. saled Staff #1 and Staff #2 cad on administrative leave ading the outcome of the ative report dated April 29, at approximately 3:35 PM		the was already in system. An agency was completed and investigation was with the staff in being placed on administrative lead immediately. The investigation took than expected to e information provid	report an initiated question ve longer nsure the	
C	ompleted on May 22 Rer the incident was	2009 tuenty (20) days		substantial due to #1 history of tell stories because he	Client ing false	.;
	02-00) Previous Varsions Cla		17	with his staff.	ļ	
,	A A . A . STATE OF CO.	Event ID: 829G11	Feel	By ID: 08G168 #	continuation shoe	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/05/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <u>OMB NO. 0938-0391</u> AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED B. WING 09G188 NAME OF PROVIDER OR SUPPLIER 05/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN'S COMMUNITY SERVICES, INC 3012 MILITARY RD, NW Washington, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG COMPLETION TAG DEFICIENCY) W 156 Continued From page 6 W 158 allegations of abuse were investigated and completed within five working day. W 159 483,430(a) QUALIFIED MENTAL W 159 RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. The facility implemented This STANDARD is not met as evidenced by: its policy on unusual Based on interview, and record review, the Qualified Mental Retardation Professional incidents regarding abuse, (QMRP) failed to ensure the coordination of neglect or abuse of an services for one of one client in the investigation. (Client #1) individual. It was reported immediately to the Program The finding includes: Director, Incident Cross Refer to W 149. The QMRP failed to Management Coordinator. /28/09 ensure the implementation of established QMRP, and his family. Both procedures of reporting all unusual incidents that impact the clients to the State Agency as staff that was on shift at evidenced by: the time of the alleged Review of an unusual incident report dated April incident were placed on 29, 2009, on May 27, 2009, at approximately 5:00 suspension without pay PM submitted by the Day Program Case Manager revealed Client #1 had alleged that a staff person pending the results of the (no name given) at his group home, had bent his investigation. The Staff in left arm towards his back, when told that he the will be trained on the needed to go to the bathroom to wash up for the day program. reporting of incidents that occur outside of our agency in an interview with the Residential Team Leader on May 28, 2009, at approximately 11:10 AM it that involve the was acknowledged that the facility did not individuals the agency document the allegation of abuse and failed to 5/25/09 notify the Department of Health (DOH) of the serves.

FORM CMS-2667(02-98) Previous Versions Obsolute

Evert ID: \$25G11

Facility ID: 09/3166

If continuetion sheet Page 7 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/05/2009 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED B. WING 09G168 NAME OF PROVIDER OR SUPPLIER 05/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN'S COMMUNITY SERVICES, INC 3012 NINLITARY RD, MY WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE TAG DEFICENCY) W 159 Continued From page 7 W 159 allegation of abuse reported by Client #1 on April The QMRP was notified of 29, 2009, according to the facility's polity. the allegation and process Review of an Incident Reporting policy dated of notifying the required October 2008, on June 1, 2009, at approximately agencies was already in 4:50 PM revealed the facility "shall have written progress. The IMC, Program documentation of all unusual incidents that impact the person served" (i.e. "instances of Director, and family. alleged or suspected abuse") "incident reports" Answers Please, DOH, and will serve to notify and inform the administration, applicable state agencies, and provide OIG were already notified documentation for subsequent review and by the Day Placement. The investigation of incidents. Incident Management Coord. There was no documented evidence the QMRP indicated that the implemented the facility's established procedures 4/28/09 of reporting all unusual incidents that impact the allegation was already in clients to the SA. the system. The investigation had already began. The staff in question was pulled from the shift and placed on suspension in accordance with the facility's policy on allegation of abuse, neglect, mistreatment, and exploitation.

FORM CMS-2567(02-98) Previous Versions Obsoleto

Event ID: SZ9G11

Facility ID: 09/3168

if continuation sheet Page 8 of 8

2023375459

PRINTED: 06/05/2009 Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (XX) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED A. WING. HFD03-0193 NAME OF PROVIDER OR SUPPLIER 05/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN'S COMMUNITY SERVICES, INC 3012 MILITARY RD, NW WASHINGTON, DC 20015 (X4) ID ( SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX (XS) COMPLETE DATE TAG DEFICIENCY 1000 INITIAL COMMENTS The Governing Body seeks 1000 to ensure that all On April 29, 2009, at approximately 1:38 PM, the State Agency (SA) was notified (via telephone) by incidents surrounding the Day Program Case Manager, who left a allegations of abuse and message to report an altegation of abuse that neglect are reported in involved Resident #1 which allegedly occurred in accordance to the policy his group home on April 29, 2009. and procedures in place On May 4, 2009 at 8:10 AM, the SA contacted the for situations involving Day Program Case Manager via telephone who individuals being served. stated that on April 29, 2009, Resident #1 reported that a staff person (no name given) at his group home, had bent his left arm towards his back, when told that he needed to go to the bathroom to wash up for the day program. An onsite investigation was initiated on May 28, 2009, to verify compliance with federal regulatory requirements, A) The allegation of abuse The findings of the investigation were based on was reported in accordance observations at the group home and one day program, interviews with Resident#1, group home to the facilities policy. and day program direct care staff, nursing and The governing body policy administrative staff, and review of client and indicates that all administrative records; including incident reports, 4/28/09 As a result of the findings the SA could not allegations shall be substantiate that Resident #1 was physically brought to attention of abused by one or more staff persons. However a and reported to the determination was made that the facility failed be Program Director. In this in compliance with the state requirements as case this was done by the evidenced by: house manager. A) The facility failed to report the aforementioned alleged abuse as required by the facility's policy and local regulations. B) The house manager notified Client #1's B) The facility failed to notify promptly the grand-mother and was resident's family/medical surrogate guardian of informed that she was an allegation of abuse. already aware. Health Regulation Administration LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TTT F (AU) DATE

PRINTED: 06/05/2009 Health Regulation Administration FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING B. WING\_ HFD03-0193 NAME OF PROVIDER OR SUPPLIER 05/29/2009 STREET ADDRESS, CITY, STATE, ZIP CODE ST JOHN'S COMMUNITY SERVICES, INC 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (XS) : COMPLIETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY 1 202 3509.2 PERSONNEL POLICIES Staff #1 job description 1202 was reviewed 9/4/08 and Each staff person shall have a written job Staff #2 job description description, which details each of his or her major 9/4/08 responsibilities and duties and supervisory was completed on 6/4/08. 6/4/08 control. The evidence of the completion is attached for This Statute is not met as evidenced by: review. Based on interview the GHMRP failed to ensure that written job descriptions for two of two direct care staff involved in the investigation were available for review. (Staff #1 and Staff #2) The finding includes: Interview with the Residential Team Leader on May 28, 2009 at approximately 12:18 PM revealed that written job descriptions for staff were in the facility's main office. Further interview revealed that the written job descriptions would be provided for review for Staff #1 and Staff #2 by May 29, 2009. There was no documented evidence to ensure written job descriptions had been provided Staff #1 and Staff #2 as of June 2, 2009. 1 206 3509.6 PERSONNEL POLICIES 1206 Staff #1 Health certificate2/4/09 Each employee, prior to employment and annually thereafter, shall provide a physician 's was completed on 2/4/2009. certification that a health inventory has been Staff #2 physical was performed and that the employee's health status would allow him or her to perform the required completed on 10/9/08. 1/9/08 duties. This Statute is not met as evidenced by: Health Regulation Administration

STATE FORM

1801

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE (DEATHFICATION NUM		(X1) PROVIDER/SUPPLIE IDENTIFICATION NO	RVCLIA MBER:	(XS) MU	LTIPLE CONSTRUC	TION		(X3) DATE	APPROV
·		HFD03-0193		B. WING			_	Ì	C
NAME OF	PROVIDER OR SUPPLIER		STREET	DOGESS OF	Y, STATE, ZIP CODE			05/	29/2009
HOL TB	N'S COMMUNITY SEF	RVICES, INC	3012 MH	LITARY RD GTON, DC	LHAP	<b>;</b>			
(X4) ID PREFIX TAG		Atement of deficiencie Y must be preceded by SC identifying informa-	8	PREPIX TAG	PROVI	DER'S PLAN OF ORRECTIVE ACT FERENCED TO DEFICIENCE	TION SHOU THE APPRI	M &	(ZS) COMPLET DATE
1206	Continued From pa	ige 2		1206	Staff #1		/	ficare	
	Based on interview	the GHURP failed to	<b>60</b> 61	1.200	was comp				
:	i mai snnuai health c	wrificatos/inventorio	* ***		Staff #2	health	certi	figste	2/4/03
!	documed for two of	two direct care staff (Staff #1 and Staff #1	Price hand		was comp				10/9/0
; ;			2)	1		-0000 01		7 40.	10/3/0
;	The finding include:	5:			)				į !
	may 28, 2009 at apprevealed that the he in the facility's main revealed that the he	esidential Team Lead proximately 12:18 PM eaith certificates for st office. Further intervi- aith certificates would for Staff #1 and Staff	aff were				·		
į	inat annual health or	nented evidence to e ertificates/ inventories and Staff #2 as of Ju	· wee						
1 374	3519.5 EMERGENC	ies .		1 374					
	guardian, his or her r no guardian, or the re sponsoring agency or soon as possible, foll	es have been secured ity notify the resident next of kin if the resid spresentative of the f the resident 's statu lowed by written notic ter than forty-eight (4)	's ent has Is as		The house notified grand-motinformed	Client :	#1's was		<b>1</b> /28/0
i i	31.Wilk (SMIGO ID DAY)	ew and record review vide evidence of the properties of significant in the contract in the con			already a		<b>→ 17 with EX</b>		
	he finding includes:		1	- 1				1	ì

Health Regulation Administration

PRINTED: 06/06/2009 FORM APPROVED

STATEMENT OF DEPIGIENCIES AND PLAN OF CORRECTION (DENTIFICATION NUMBER  (X1) PROVIDER/SUPPLIERA (DENTIFICATION NUMBER)		ERVCLIA IMBER:	A. SUILL		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER SYDEET				S. WING	C	
					Y, STATE, ZIP CODE	05/29/200
	N'S COMMUNITY SER		MASHING	ITARY RD, STON, DC	NW 20015	
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY TO IDENTIFYING INFORMA	CC 14 4	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	4 H Avenue 1 100
1 379 3	PM submitted by the	at incident report data, 2009, at approximate Development of Development all surrogate document of Development of Development and Surrogate document of Development of Deve	ately 5:00  red that a p home, when told wash up  y 28, ed as his family ion of  hent sent rt #1 gal  actility the of an  3519,5, of ler	1374	The report was complete by the Day Placement QMRP was notified of the allegation and professions are adjusted to agencies was already progress. The IMC, Progress. The IMC, Progress. The IMC, Progress. The IMC, Progress. The IMC, Progress, and family Answers Please, DOH, OIG were already not by the Day Placement Incident Management indicated that the allegation was alread the system. The investigation had allegan. The staff in question was pulled the shift and placed suspension in accordant with the facility's progression of abusine progression of abusine progression.	eted The  process puired in rogram and 1/29/ ified The Coord. dy in ready from on ance policy se,

Health Regulation Administration PRINTED: 06/05/2009 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING HPD03-0193 B. WING NAME OF PROVIDER OR SUPPLIER 05/28/2009 STREET ADDRESS, CITY, STATE, 2P CODE ST JOHN'S COMMUNITY SERVICES, INC 3012 MILITARY RD, NW WASHINGTON, DC 20015 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY PULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDERS PLAN OF CORRECTION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAR (X5) COMPLETE DEFICIENCY 1379 Continued From page 4 1379 twenty-four (24) hours or the next work day. The QMRP was notified of the allegation and process of notifying the required This Statute is not met as evidenced by: agencies was already in Based on interview and record review, the progress. The IMC, Program GHMRP falled to ensure the Department of Health (DOH), Health Facilities Division was birector, and family. **4/28/09** immediately notified, followed by written Answers Please, DOH, and notification within 24 hours, of unusual incidents that substantially interfered with a resident's DIG were already notified health, for one of one resident that resided in the by the Day Placement. The investigation. (Resident#1) Incident Management Coord.. The finding includes: indicated that the allegation was already in Review of an unusual incident report dated April 29, 2009, on May 27, 2009, at approximately 5:00 the system. The PM submitted by the Day Program Case investigation had already Manager revealed Resident #1 had alleged that a staff person (no name given) at his group home, began. The staff in had bent his left arm towards his back, when told question was pulled from that he needed to go to the bathroom to wash up the shift and placed on for the day program. suspension in accordance interview with the Day Program Case Manager with the facility's policy on May 29, 2009, at approximately 1:44 PM revealed a telephone massage was left at the on allegation of abuse, facility (time unknown) on April 29, 2009, neglect, mistreatment, and regarding Resident #1's allegation of abuse. Further interview revealed the facility's House exploitation, Manager (HM) called the Day Program Case Manager on April 29, 2009, at approximately 3:05 PM and was informed of Resident #1's ellegation of abuse. In an interview with the House Manager on May 28, 2009, at approximately 11:10 AM it was acknowledged that the facility did not document the allegation of abuse and failed to notify the Health Regulation Administration STATE FORM

Health Regulation Administration STATE FORM

D PLAN OF CORRECTION	(XI) PROVIDER/SUPPLE IDENTIFICATION NU HFD03-0193	ERVOLIA MABER: A. BURLI S. WINK			ETED C
ME OF PROVIDER OR SUPPLIER T JOHN'S COMMUNITY SER	Vices, inc	STREET ADDRESS, GIT 3012 MILITARY RD WASHINGTON, DC	. NW	05/2	29/2009
	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA		PROVIDERS PLAN OF CORRE (EACH CORVECTIVE ACTION SH CROSS-REFERENCED TO THE APT DEFICIENCY)	AYR OF	COMPLE DATE
Review of an Incider October 2008, on Ju  4:50 PM revealed th	th (DOH) of the alleg Resident #1 on April 2 ility's polity.  Int Reporting policy do the 1, 2009, at approxime 1, 2009, at approxime facility "shall have to unusual incidents the erved" (I.e. "instances d'abuse") "Incident re d'inform the administracies, and provide ubsequent review and ents.  Tented evidence the fittilished procedures a	eted eximately written est s of sports" stration, d facility of t the	The OMRP was notified the allegation and pof notifying the requirements was already progress. The IMC, Poirector, and family Answers Please, DOH, OIG were already notify the Day Placement Incident Management indicated that the allegation was alread the system. The investigation had also began. The staff in question was pulled in the shift and placed suspension in accordance with the facility's pon allegation of abusinessed, mistreatment exploitation.	rocess uired in rogram and ified The Coord. dy in ready from on ance policy se,	28/09

Health Regulation Administr	ation				FOR	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PEAN OF CORRECTION IDENTIFICATION NUMBER:		(XZ) MUI A. BUILD B. WING		(43) BATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER	MFD03-0193				OK	C <b>29/2</b> 009
		STREET AD	DRUEBB, CITY	, STATE, ZIP CODE	- VOI	Lat EVUS
ST JOHN'S COMMUNITY SER	i	3012 Mili Washing	TARY RD, ITON, DC	NW 20015		٠
	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	W P. P.	GOMPLETE DATE
the Day Program Camessage to report a involved Resident # his group home on A On May 4, 2009 at 8 Day Program Case # stated that on April 2 reported that a staff his group home, had back, when told that bathroom to wash up An onsite investigatic 2009, to verify compirequirements.  The findings of the in observations at the grogram, interviews y and day program dire administrative staff, a administrative record: As a result of the finding substantiate that Resi	it approximately 1:38 vas notified (via telepise Manager, who let it allegation of abuse it which allegatiy occupil 29, 2009, and allegatiy occupil 29, 2009, and allegatiy occupil 29, 2009, Resident #1 person (no name giver) person (no name giver) bent his left arm towheneaded to go to the option of the day program on was initiated on Milance with federal regions were basing the sale could not exist the Sale could not give the Sale co	et on day phone and ne corts.	1	The Governing Body s to ensure that all incidents surroundin allegations of abuse neglect are reported accordance to the po and procedures in pl for situations invol- individuals being se  A) The allegation of was reported in acco- to the facilities po- The governing body po- indicates that all allegations shall be brought to attention and reported to the Program Director. In case this was done by house manager  B) The house manager	g and in licy ace ving rved. abuse rdance licy. olicy of this y the	/28/09
abused by one or more determination was made in compliance with the evidenced by:  A) The facility falled to alleged abuse as requested and local regulations.  B) The facility falled to resident's family/medican allegation of abuse.	re staff persons. How de that the facility to a state requirements report the aforement ired by the facility's notify promptly the	vever a iled be as itioned policy		notified Client #1's -mother and was infor that she was already aware.	grand med	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XR) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSU (X1) PROVIDERSU (X1) PROVIDERSU		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	UMBER: "		(22) MULTIPLE CONSTRUCTION  A. BUILDING		SURVEY
		HFD03-0193		B. WING		P .	C
AME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	STREET ADD	ORESS, CITY	STATE, ZIP CODE		29/2009
NHOL T	'S COMMUNITY SE	RVICES, INC	3012 MILI WASHING	TARY RD, TON, DC :	NW 20015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING IMPORMA	EN M .	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLE DATE
R 122	Continued From pa	age 1		R 122			1
R 122	4701.2 BACKGRO	UND CHECK REQUI	REMENT	R 122	Staff #1 backgrou	nd check	
-	Except as provided	t in section 4701.6, ea			was completed on		(  3/11/
[	facility shall obtain	a criminal background	check		Staff #2 backgrou		3,24,
1	and shall either obli- District of Columbia	tain or conduct a chec a Nurse Aide Abuse R	k of the		was completed on		
1	before employing a	Ore employing or using the contract service			Please review att	achments :	1/26/
	of an unlicensed pe	erson,			for details.		
P	criminal backgroun before employing 2	the GHMRP failed to d checks had been of out of 2 direct support stigation. (Staff #1 and	otained ot staff				
:	The finding include:	<b>E</b> ;					i
	May 28, 2009, at aprevenied that the standard that the standard in the interview revealed to be processed to be processed.	lesidential Team Lead oproximately 12:15 Phastic criminal backgrour facility's main office, F that the criminal backgrovided for review for S yed in the facility by Market in	id Turther Tround Staff #1				· · · ·
	anminai backgroung	mented evidence to end checks had been obtain #1 and Staff #2 as	tained			į	
	,					,	,
i				ļ			
I				1		:	